the disease to become bilateral, we found that patients with bilateral involvement were taking far less time to get to treatment than unilateral patients, in fact less than half the time. While the time between onset and initiation of treatment for bilateral cases was 0.344 years, the comparable figure for unilateral cases was 0.737 years. These figures throw doubt on the efficacy of treatment in prevention of bilaterality and support the idea that bilateral cases are most commonly bilateral from early in the history of the disease.

Finally we should like to say that we do agree with Dr. Westin, whose contributions in this field are well known, that these children should be treated, and in fact should be treated just as he does based upon the best available current knowledge. In particular, we trust that no one will confuse this admittedly stringent interpretation of the literature with inadequate diagnostic measures (inasmuch as other conditions may simulate Legg-Perthes disease but demand different treatment), and similarly with the need for careful follow-up regardless of the treatment elected.

Asking for statistical validation of conclusions regarding treatment methods is not the same as recommending that nothing be done.

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Pressure on the Colon

TO THE EDITOR: Doctor Shulman [Shulman AG: High bulk diet for diverticular disease of the colon. West J Med 120:278-281, Mar 1974] deserves credit for calling our attention to new concepts in the field of diverticular bowel disease.

Its increase during the last century he traces to changes in food habits causing a reduction in colonic bulk. Higher intracolonic pressure leads to excessive thickening of the colonic musculature and, in turn, to diverticulosis.

His arguments have a formidable range, from his own clinical observations to experimental work of others, from geographical, historical and statistical data to anthropological evidence.

Yet, besides the mere eating habits, there are, I submit, other anthropological factors which involve the development of diverticular disease:

Cultural: In our lives it is common that people find it either physically impossible or socially improper and embarrassing to promptly answer the call of nature and tend to wait for hours to retire to the stool. When harnessed to our work or engaged in social functions we allow our high intracolonic pressure level to persist and to build up.

In contrast, so I am told from first-hand observation, villagers in India use the open field; women in groups trek out before sunrise for their quick, simple open-air ritual.

Sanitary: Western civilization has tended to give up the outhouse: the place was cold, smelly and verminous. In its unattractive air the task was performed with physiological expeditiousness. In its stead, we now retreat to the comforting privacy of a well-appointed bathroom and, contemplating the decor and sweet scent, we inadvertently delay the healthy release of the intracolonic pressure.

Literary: We literate people have succumbed to a further hazard: I am amazed how many take a magazine or a book with them and read instead of going on with the business at hand. An obnoxious innovation of our civilization is the magazine rack near the stool. It always has suggested to me that diverticulosis coli is in the house. Another added attraction and distraction to prolong the session is a handy radio.

I believe it is fair to postulate that there is, besides the colonic pressure rise per se, the role of a second factor, the *duration* of the high pressure level.

Doctor Shulman's approach should not only reduce the *level* of pressure, by more bulk, but also reduce its excessive *duration* by sounder cultural habits.

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More on Bran

TO THE EDITOR: A correction on the Letter to the Editor by Lucas W. Empey, MD. [West J Med 120:501, Jun 1974]:

Having read and listened to "Mr." Painter of England carefully explain the importance of bran in the diet and *how to use it,* may I detail proper use to avoid chronic pain from excess use.

First, it is the fiber in unrefined bran that is the important ingredient—so whole bran or "natural" bran flakes is to be used, not 40% Bran Flakes® nor compressed pellets such as All-Bran®.

Dosage starts at two teaspoons per day raising it by one teaspoon at weekly intervals until soft easy bowel movement(s) daily ensue. ["9" per day was the highest dose needed, "Mr." Painter stated.]

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